DEFINITIONS
A Monthly Look at
UN Terms and Ideas

September 29, 2023 | Issue 33

Why Abortion is Not the Solution to Maternal Mortality

By Rebecca Oas, Ph.D.

INTRODUCTION

Among those who advocate for abortion as a human right, the talking points are well-worn and deceptively simple: abortion complications are a major contributor to maternal deaths and injuries, the only alternative to "unsafe" abortion is "safe" abortion, and national laws and policies should be amended to maximize the availability and acceptability of this procedure as a component of basic health care. For those who take a pro-life position—specifically, those who hold that human beings are persons both before and after birth and have intrinsic human dignity from conception to natural death—these arguments must be opposed, but to disprove them requires reexamining many of the seemingly innocuous methods and terminologies used in the field of maternal health. This paper explores the ways in which the medical and scientific fields have been weaponized against unborn human life and how ideology masquerades as "facts" and "evidence" to promote this deadly agenda.

How maternal deaths are defined

According to the World Health Organization (WHO), maternal mortality is defined as "the annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, expressed per 100,000 live births, for a specified time period."[1] It is important to note that while this definition

C-Fam | Center for Family & Human Rights
New York · Washington, DC

is widely used and broadly accepted, it is not the result of an inevitable process, but the product of specific decisions made by persons with specific aims in mind.

The phrase "or its management," in particular, brings together several dissimilar elements. Pregnancy and childbirth are natural processes, and fundamental to the propagation of the human species, but they do carry risks of complications that can be injurious or fatal to the mother, the child, or both; thus, the need for "management." Medical interventions that prevent or treat common complications of pregnancy, birth, and infancy have greatly reduced maternal and child mortality around the world. These interventions are deployed with the intended goal of ensuring the survival of two patients and do not regard pregnancy or birth as a zero-sum situation where either life may be regarded as expendable. Even if these interventions fail to save both lives, to the extent that this is possible, it is their goal. In contrast, induced abortion has the aim of terminating not only a pregnancy, but the life of the fetus, or unborn child. In contrast to other maternal health interventions, which aim to preserve two lives, induced abortion aims to preserve one life—that of the mother—while ending the life of the child. The fact that abortion complications may also claim the mother's life accounts for such deaths to be included within "maternal mortality," but there is a fundamental difference between these deaths and other maternal deaths. In one case, a natural process encountered complications that were not remedied by medical interventions (or may even have been exacerbated by them), and in the other case, an intervention with an expressly lethal intention was used to disrupt a natural process.

Medical interventions that prevent or treat common complications of pregnancy, birth, and infancy have greatly reduced maternal and child mortality around the world.

In contrast to other maternal health interventions, which aim to preserve two lives, induced abortion aims to preserve one life—that of the mother—while ending the life of the child.

The WHO also draws a distinction between *direct* and *indirect* maternal deaths. Direct maternal mortality is defined as "resulting from obstetric complications of the pregnant state (pregnancy, labor and puerperium), and from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above." Indirect maternal deaths are those "resulting from previous existing disease or disease that developed during pregnancy and not due to direct obstetric causes but were aggravated by the physiologic effects of pregnancy." There is also an even broader concept referred to as "comprehensive maternal deaths" or "pregnancy-related deaths" that refers to "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death (obstetric and non-obstetric)."[2] This incorporates deaths resulting from accidents and other incidental causes, including suicide, which may be related to postpartum depression.

The WHO also draws a distinction between direct and *indirect* maternal deaths.

The U.S. Centers for Disease Control and Prevention (CDC) defines a "pregnancy-related death" as "the death of a woman

during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy." This casts a wide net, both in terms of causes of death and in terms of the relevant time frame, which extends well beyond the WHO definition of 42 days after the end of the pregnancy. This dramatically changes the data that is collected; the CDC's analysis of maternal deaths in 36 U.S. states between 2017 and 2019 found that "among pregnancy-related deaths with information on timing, 53% occurred 7-365 days postpartum."[3] One category of deaths, "injury" included intentional injury (homicide) as well as unintentional injury, such as from overdose, car accidents, and other types of accidents.

The purpose of this section is not necessarily to advocate for one definition of "maternal death" over another. Rather, it illustrates the fact that the definitions of terms may differ, in large and small ways, between organizations and contexts, and that these definitions are both upstream and downstream of policies and priorities. In the U.S., homicide is a leading cause of death for pregnant women.[4] The inclusion of these deaths under the heading "maternal" serves the advocacy goals of those wishing to draw attention to this fact. Meanwhile, it inflates the number of maternal deaths being reported, while bringing with it other incidental and accidental deaths that might be better discussed in terms of policies to improve automotive safety rather than maternal health.

In the U.S., homicide is a leading cause of death for pregnant women. The inclusion of these deaths under the heading "maternal" serves the advocacy goals of those wishing to draw attention to this fact.

How abortion is defined

As with "maternal mortality," the definition of the word "abortion" is not always as straightforward as it might appear, and how it is defined has important political and philosophical implications. When it is used to describe a cause of maternal death or injury, "abortion" typically refers to complications of both *spontaneous* abortion (also referred to as miscarriage) and *induced* abortion caused by surgical, chemical, or other means. In some contexts, where information is unavailable (or may be intentionally withheld), it may be difficult to determine whether the miscarriage related to complications that caused a woman's death was spontaneous or induced. When a woman is suffering from complications of miscarriage or induced abortion, in many cases, the treatment would be similar or the same. For instance, in its recent abortion guidance, the WHO states that "uncomplicated incomplete abortion can result after an induced or spontaneous abortion (i.e., miscarriage). The management is identical and the above recommendations apply to both."[5]

As with "maternal mortality," the definition of the word "abortion" is not always as straightforward as it might appear.

While complications of induced abortion and miscarriage may require similar management, the two things are not at

all similar in terms of intent, or, in many places, their legal ramifications. The fact that the word "abortion" is sometimes used to characterize both cases has sometimes been used to obfuscate the important legal and moral distinctions between them. After the U.S. Supreme Court overturned the 1973 *Roe v. Wade* ruling that interpreted a constitutional right to abortion across the entire country, the New York Times published an article attempting to map out the newly-arising legal and semantic disputes over how "abortion" was defined. After quoting a Harvard Medical School doctor and bioethicist's arguably unhelpful triple-tautology: "an abortion is an abortion is an abortion," the article provides examples of how the terminology used by medical experts, lawyers, and the general public can overlap and contradict each other, creating a particularly emotionally-charged and legally consequential type of confusion.[6]

While complications of induced abortion and miscarriage may require similar management, the two things are not at all similar in terms of intent, or, in many places, their legal ramifications.

Prior to the overturning of *Roe,* a group of obstetricians and gynecologists launched the Dublin Declaration on Maternal Healthcare in an attempt to provide some clarity on the issue. In it, they "affirm that direct abortion – the purposeful destruction of the unborn child – is not medically necessary to save the life of a woman," and go on to explain the medical and bioethical rationale for this statement.[7] The Declaration asserts that "the prohibition of abortion does not affect, in any way, the availability of optimal care to pregnant women," while defending the interventions needed to save women's lives and may be unable to save the child's life as well, though the intention is to save both.

Again, the intention is key.

Again, the intention is key. In any dispute over abortion as it relates to maternal health, the question must be asked whether there *are* two lives to be saved (that is, that the unborn child is in fact still alive), and whether, as far as possible, efforts are being made to save them both. One example where the second question could not be answered affirmatively is a case where the mother's life and health are not in jeopardy, but the unborn child has been diagnosed with a condition that may prove terminal before or shortly after birth, and where induced abortion would be used as a form of euthanasia.

Death or the threat of death: a false choice

Internationally, maternal mortality has declined significantly. From 2000 to 2015, UN statistics show a reduction in the global maternal mortality ratio of 33%, "and by more than half in 58 countries with the highest rates of maternal mortality."[8] While progress has slowed—and even reversed in some cases, exacerbated by the COVID-19 pandemic—it is undisputed that the interventions exist to prevent or treat most complications of pregnancy and childbirth, and further efforts are necessary

to ensure that they reach women in the most poor and remote countries, regions, and situations.

Historically, deaths related to pregnancy and childbirth have been far higher. At the beginning of the twentieth century, in the U.S., six to nine women died from direct maternal causes for every 1,000 live births.[9] To frame this in terms of the maternal mortality ratio indicator used in the Sustainable Development Goals, that is 600-900 maternal deaths per 100,000 live births, compared with 21 as of the most recent UN estimate.[10] By the year 1960, the U.S. maternal mortality ratio was 37 deaths per 100,000 live births.[11] In 1967, Colorado became the first U.S. state to legalize abortion in certain cases, followed by others including New York, which legalized abortion on demand up to the 24th week of pregnancy. In 1973, *Roe v. Wade* overrode state-level abortion restrictions. A look at the timeline of maternal mortality in the U.S. shows that the lion's share of improvements in maternal survival took place before the feminist movement succeeded in liberalizing state-level abortion laws. The advent of modern medicine, including antibiotics, combined with the political will to ensure women's and children's survival, were far more consequential. By the time *Roe v. Wade* was decided, both birth rates and maternal mortality had declined, and deaths in childbirth were far less common than they had been less than a century earlier.

Historically, deaths related to pregnancy and childbirth have been far higher.

By the time *Roe v. Wade* was decided, both birth rates and maternal mortality had declined, and deaths in childbirth were far less common than they had been less than a century earlier.

The fact that the U.S. still has higher maternal mortality than its highly-developed peers remains both a medical and political challenge, as well as a talking point used by abortion activists who routinely argue that abortion is safer than birth. Setting aside the obvious counterargument that no procedure that is intended to kill one human life and carries the risk of killing two can reasonably be called "safe," the comparison is one of apples and oranges. In 2013, Dr. Byron Calhoun published an article dismantling the comparison in detail, citing the incompleteness of data, the incompatibility of definitions of terms in the data being collected, and other methodological problems.[12] One critical discrepancy arose from the fact that, while the category of "maternal deaths" had been stretched to contain deaths from suicide, accident, or other unrelated cause up to a year after the end of pregnancy. While births, including premature births and stillbirths, are generally well-documented, abortion in the U.S. was significantly underreported before the *Dobbs* decision that overturned *Roe,* and is likely to be even more underreported post-*Dobbs.* CDC abortion estimates exclude several states which do not have reporting requirements, including California, which is the most populous U.S. state. As abortion is increasingly performed using pills rather than surgery, and as abortion advocates increasingly promote self-induced abortion at home, using pills acquired

One critical discrepancy arose from the fact that, while the category of "maternal deaths" had been stretched to contain deaths from suicide, accident, or other unrelated cause up to a year after the end of pregnancy.

via telehealth or even illegal providers shipping them from overseas, abortion rate estimates will likely become even more unreliable and likely to undercount. This will have two effects: first, mortality and morbidity resulting from complications of induced abortion will often be attributed to a spontaneous miscarriage—this is in fact encouraged by illegal abortion pill providers like Aid Access, who sell pills from overseas to women in the U.S. and, should complications arise, advise, "you can say that you think you have had a miscarriage,"[13] and "the doctor will not be able to see or test for any evidence of an abortion, as long as the pills have completely dissolved."[14] Second, indirect deaths in the year following an abortion, including from suicide or self-harm that could be related to the abortion, will be far less likely to be coded as pregnancy-related or maternal deaths, as the year-long timeframe will be irrelevant if the abortion itself is not recorded as a starting point. In both instances, deaths related to induced abortions will be underestimated, while deaths otherwise related to pregnancy and birth are expanding to include an ever-wider range of deaths, including some that are deliberately miscategorized.

In both instances, deaths related to induced abortions will be underestimated.

In October 2022, Harvard researchers published an editorial in the British Medical Journal about homicide being a leading cause of death for pregnant women in the U.S. Specifically, they stated that women are "more likely to be murdered during pregnancy or soon after childbirth than to die from the three leading obstetric causes of maternal mortality."[15] The authors, interviewed in U.S. News and World Report, used the article to make the case for more restrictive gun laws—and abortion, arguing, "women may be facing more risk because of the recent dismantling of reproductive rights in the United States," and "restricting access to abortion may worsen the risks in abusive relationships."[16] For those determined to promote abortion, it can be framed as a solution even for the most indirect causes of maternal mortality: women must be free to choose death for their unborn children, or else face it themselves.

Hard cases make bad law

The argument that abortion is necessary to save women from maternal mortality relies on several deceptive tactics. As previously discussed, complications of induced abortion are unlike other direct causes of maternal death, as the cause of the complications is artificially inflicted. Arbitrary decisions regarding the definition of terms like "maternal death" and "abortion," as well as invalid comparisons, incomplete reporting, and intentional obfuscation add to the confusion. In some cases, the law itself becomes a work of medical fiction, as in the case of the United Kingdom, where the government regularly publishes abortion statistics for England and Wales. The U.K.'s

The argument that abortion is necessary to save women from maternal mortality relies on several deceptive tactics.

Abortion Act 1967 provides for specific grounds under which abortion may be lawfully performed, including one that allows abortion provided that "the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman." In 2021 98% of abortions were allowed under this ground, and within that number, 99.9% were attributed to risks to the woman's mental health rather than her physical health, classified as "mental disorder, not otherwise specified."[17] Only two abortions were attributed to the grounds "to save the life of the pregnant woman" or "to prevent grave permanent injury to the physical or mental health of the pregnant woman." This report is extremely similar to those published in previous years.

Only two abortions were attributed to the grounds "to save the life of the pregnant woman" or "to prevent grave permanent injury to the physical or mental health of the pregnant woman."

In recent years, international feminist groups have increasingly called for the decriminalization of abortion, as well as access to it on demand, paid for under nationally-funded health care schemes. While the U.K. still criminalizes abortion in law, with exceptions, their own national abortion statistics reveal that in practice, even if not in law, abortion on demand is the reality in that country. The unspecified mental health risks ostensibly averted are a matter of legal and medical fiction, a fig leaf covering the elective choice to end one category of human lives while offering little evidence of saving or improving the lives of another group.

In the U.S., the overturning of *Roe* led to an outpouring of concern by abortion advocates that women's lives would be lost. Over a year later, progressive outlets like ProPublica are publishing articles trying to explain why it's so difficult to prove that this is happening: "It may be difficult or impossible to track the number of lives lost due to limits on abortion access."[18] Among the reasons cited for this is the fact that the actual number of U.S. maternal deaths is small, and those that do occur are often the result of multiple factors.

Small sample sizes—even a sample of one—have been used to remarkable effect by abortion activists in the past. The case of Savita Halappanavar, who lost her life from complications of a miscarriage, exacerbated by alleged medical mismanagement,[19] became a *cause célèbre* in the ultimate overturning of Ireland's pro-life constitutional provision. Prior to her death, and the successful campaign to legalize abortion in Ireland, the country had been counted among the safest countries for women to give birth (6 maternal deaths per 100,000 live births in 2008).[20]

Small sample sizes—even a sample of one—have been used to remarkable effect by abortion activists in the past.

In countries like Ireland, the U.K., and the U.S., most women survive giving birth, as do their children. Deaths related to induced abortions are also relatively rare—including in Ireland prior to the change in its law—and for a similar reason: quality

health care is broadly available, as are skilled professionals to provide it. Access to medicines, clean water and sanitation, transportation, and other basic infrastructure and utilities is widespread. Education, particularly for women and girls, is prioritized. In highly developed countries like these, most elective abortions are not performed for the purpose of saving the mother's life, and as the Dublin Declaration points out, in a true life-and-death situation, procedures to save the mother's life are distinct from those whose purpose is to end the life of the unborn child and not the same as an induced abortion.

Given their relative wealth and high living standards, the fact that Western countries tend to have more liberal abortion laws compared with the rest of the world only points to the callousness of those laws. The global regions that for over a century have led the world both in wealth and maternal survival did not achieve those things by legalizing abortion; that came after, and in some cases, long after. Nevertheless, the message from many Western governments to the global South, both in UN negotiations and in the way they spend their aid money, is that in order to save maternal lives, abortion must be decriminalized, legalized on demand, provided by the government, and paid for by taxes from their citizens.

How abortion activists exploit maternal mortality to push abortion on Africa

Ireland and the U.S. serve as useful examples of how, even in countries where maternal mortality is low, when abortion restrictions are debated at the legal and political level, the argument that "women will die" is used, and often effectively. In countries and regions where maternal mortality is higher, and where abortion laws are generally more restrictive, these same arguments are being used: governments are told that in order to improve maternal health outcomes and achieve national and global goals, they must liberalize their abortion laws. Countries that have resisted the attempts by activists, including those operating as independent UN human rights experts, to insinuate a right to abortion into international human rights law, are being told that they should treat abortion effectively as a right for pragmatic purposes; otherwise, women will die.

Governments are told that in order to improve maternal health outcomes and achieve national and global goals, they must liberalize their abortion laws.

One organization working to build the argument that legal, accessible abortion is necessary to improve maternal health outcomes in Africa is the African Population and Health Research Center (APHRC), which describes itself as "the continent's premier research institution and think tank."[21] While touting itself as "African-led," the center's sources of funding include Western governments such as Sweden and the U.S., Western foundations such as Packard, MacArthur, and Rockefeller, Western-based corporations such as MasterCard

One organization working to build the argument that legal, accessible abortion is necessary to improve maternal health outcomes in Africa is the African Population and Health Research Center (APHRC).

and Google, UN agencies, and a selection of nongovernmental organizations that includes Ipas and the Safe Abortion Action Fund, both of which are entirely dedicated to abortion advocacy.[22]

In 2012, APHRC partnered with the pro-abortion Guttmacher Institute and Ipas to produce a study supported by funding from the governments of the U.K., Sweden, and the Netherlands. The report, titled "Incidence and Complications of Unsafe Abortion in Kenya," and contains a foreword by Kenyan director of medical services Dr. Francis Kimani calling it "a wake-up call on the reality of unsafe abortion in Kenya and the need to urgently find a lasting solution to this preventable cause of maternal morbidity and mortality."[23]

The study was widely cited, particularly by organizations in favor of liberalization of Kenya's abortion laws, which only allow abortion when a woman's life or health is in danger and emergency treatment is necessary. However, doctors in Kenya have spoken out to dispute its figures and findings. They accused the authors of greatly exaggerating the number of maternal deaths, as well as the share of deaths related to induced abortion, and pointed toward the indisputably political aims of the authors and their funders.[24]

The findings of the study follow a predictable script: abortion as a leading cause of maternal deaths in Kenya, and these deaths being preventable by increased contraceptive use and increased provision of "safe" abortion, enabled by more permissive laws. The fact that the study was narrowly tailored to produce this result is evident from the way it treats complications of spontaneously occurring "late" miscarriages between 12- and 22-weeks gestation which require medical intervention. The rate at which this occurs is estimated for one purpose: to subtract it from the total population of women suffering complications that could either arise from spontaneous or induced pregnancy termination in order to focus on the latter, which are repeatedly characterized as preventable if the authors' policy prescriptions are enacted.

In any setting where birth or miscarriage complications are frequently fatal, it is not reasonable to think that abortion can be "safe" for women either.

Having obtained an estimate of the rate of induced abortions and their complications by subtracting the spontaneous miscarriages, the study authors proceed to subdivide the maternal deaths accordingly, giving no further attention to those related to late miscarriages—these, presumably, are not regarded as preventable for the purposes of the study. Even so, the opposite is true: in any setting where birth or miscarriage complications are frequently fatal, it is not reasonable to think that abortion can be "safe" for women either. Dr. Wahome Ngare, a Nairobi-based physician critical of the APHRC study, noted that the causes of Kenya's maternal mortality

are the same as those reported by the WHO: hemorrhage, infections, high blood pressure, complications from delivery and abortion, in that order.[25] If health systems are equipped to handle obstetric emergencies, such as bleeding and infection, and underlying infrastructure including physical clinics, transportation, electricity, and clean water are in place, then women's lives will be saved, regardless of whether the bleeding or infection resulted from a natural complication or an induced one. When these things are not in place, maternal deaths from all causes will remain high. This is a key reason why Ireland, as well as other countries such as Chile[26] became regional and even global leaders in maternal health outcomes while maintaining—or even strengthening—their laws protecting the unborn: they focused on improving systems for maternal health and health care more broadly, not on politically contentious and more narrowly applicable abortion legislation.

To return to the Kenyan APHRC study and its population of women experiencing potentially-fatal miscarriage complications who were included only to be neglected, the only remaining message is that they should have used contraception, which the report also uses every available opportunity to promote.

African governments, as well as leaders in countries with pro-life laws in other regions, are being bombarded with the message that if they will not provide legal abortion on demand for human rights reasons, they should at least do it to avoid having pregnant women's blood on their hands. A follow-up report published in 2018 by the same organizations attempted to calculate the costs of treating the complications of "unsafe" abortion in Kenyan public health facilities.[27] Once again, the argument is that Kenya's pro-life laws are imposing a heavy burden on the country, this time on its financial resources.

African governments are being bombarded with the message that if they will not provide legal abortion on demand for human rights reasons, they should at least do it to avoid having pregnant women's blood on their hands.

Central to the pro-abortion organizations' argument is the idea that abortion is inevitable, and if it is not done "safely," it will only be done "unsafely." As with "maternal mortality" and "abortion" itself, the definition of what constitutes a "safe" abortion is also constantly shifting due to policy priorities.[28] In attempting to define "safe abortion," the WHO included the caveat that such definitions "are not static; they evolve in line with evidence-based WHO recommendations."[29] In other words, its definition at any given time is simply what the WHO says it is.

Central to the pro-abortion organizations' argument is the idea that abortion is inevitable, and if it is not done "safely," it will only be done "unsafely."

Pushing back on the selective fatalism of the SRHR agenda

Organizations like APHRC and the Guttmacher Institute hold themselves out as sources of evidence-backed factual information that leaders can use to create and implement policies that are, to use their frequent wording, "not only the right thing to do, but the smart thing to do." The idea that their

priorities are “the right thing to do” is based on the positions of experts within the UN human rights system whose opinions on what constitutes a human right is often entirely divorced from what UN member states have agreed to through negotiated consensus. In addition to relying on the moral authority—such as it is—of independent experts operating under the Office of the High Commissioner for Human Rights (OHCHR), sexual and reproductive health and rights (SRHR) advocates similarly attempt to bypass international consensus by trading on the credibility of UN agencies, particularly when these agencies exceed their own mandates on controversial issues. Abortion advocates lobbied the WHO to include abortion pills, without caveats, on model essential medicines lists. They then lobbied governments and the general public to accept the drugs as safe based on the fact that the WHO includes them on such lists.[30]

Abortion advocates lobbied the WHO to include abortion pills, without caveats, on model essential medicines lists.

When it comes to the issue of abortion and maternal mortality, we can see from the U.S. how official government statistics can be incomplete when reporting requirements are patchy, and how the way terms are defined can produce wildly different numbers (as in the case of direct vs. indirect maternal mortality). When an organization like APHRC, Ipas, or the Guttmacher Institute publishes a study, it can be assumed from the outset that it will contain information that supports their political position, packaged in a way that frames their political priorities as the obvious and necessary solutions. Findings that might emerge in the process of performing the study that do not support their aims will likely be omitted from the final report, and categories and terms will be defined in the way that produces results most favorable to the desired outcome.

The idea that behaviors can be changed by policy interventions is clearly envisioned by these groups; in the 2013 Kenyan study, its recommendations include “engaging and educating communities” about “the detrimental effects of abortion stigma and misinformation about family planning and contraception.”[31] Meanwhile, providing pregnant women with alternatives to abortion or addressing the underlying factors that lead women to see abortion as desirable or even necessary are not mentioned or envisioned.

Educating young people about the importance of abstinence or fidelity to one’s committed partner or spouse is denigrated by SRHR advocates in favor of “comprehensive sexuality education.”

A similar situation can be seen with regard to the SRHR agenda more broadly. Educating young people about the importance of abstinence or fidelity to one’s committed partner or spouse is denigrated by SRHR advocates in favor of “comprehensive sexuality education” which promotes abortion and homosexuality and insists that all sexual behavior is equally valid as long as it is consensual. If the costs to health systems of treating abortion complications are high, one can only imagine what an accounting of the costs of treating the effects of irresponsible and risky sexual activity would reveal, including

the impact of crisis pregnancies and the harms to children born outside stable families, sexually transmitted infections, and other effects on the emotional and psychological health of the public.

The message is clear: any commitment to improve maternal health and strengthen families that does not also include abortion and "sexual rights" will be strongly opposed

In 2020, the Geneva Consensus Declaration (GCD) was signed by a coalition of over 30 countries, affirming that women's health, including maternal health, should be prioritized, but that this does not include abortion. It asserted the importance of national sovereignty, including on issues like abortion laws, which are, according to consensus, solely for countries to determine, and affirmed the importance of the family. It drew its content entirely from documents negotiated and agreed to by UN member states.[32] Predictably, the GCD was sharply criticized by SRHR advocates, including the Guttmacher Institute, which described it as "perhaps the most extreme example of how the administration used an antiabortion ideology to score political points internationally."[33] The message is clear: any commitment to improve maternal health and strengthen families that does not also include abortion and "sexual rights" will be strongly opposed by those who see reducing maternal mortality as a convenient and relatively uncontroversial entry point for contentious issues that are repeatedly rejected in negotiations.

What truly defines a "maternal" death is that it involves a mother, which means it also involves a child.

Pushing back on attempts to hijack the issue of maternal health by the abortion lobby requires understanding that even the language being used to discuss the issue, and the indicators being measured to quantify it, have become politicized and cannot merely be taken at face value. Furthermore, people on both sides of the abortion issue agree on one thing: it is tragic and often preventable when a woman dies from induced abortion complications, and efforts should be made to prevent such deaths. However, we cannot lose sight of the fact that what truly defines a "maternal" death is that it involves a mother, which means it also involves a child. To argue that the only alternative to "safe" abortion is "unsafe" abortion means accepting at face value that the child's life is not worth trying to save, too.

In a world where the global community agreed to make the elimination of poverty in all forms as only one of its seventeen Sustainable Development Goals, our level of ambition to improve maternal and child survival should not be so low as to accept the loss of either as inevitable.

ABOUT THE AUTHOR

Dr. Oas is Director of Research at C-Fam. She earned her doctorate in genetics and molecular biology from Emory University.

Rebecca Oas, Ph.D.
Editor

DEFINITIONS is published monthly by the Center for Family & Human Rights (C-Fam).

757 Third Ave, Suite 2119
New York, New York 10017

info@c-fam.org
www.c-fam.org

Endnotes

1 World Health Organization. Global Health Observatory; Indicator Metadata Registry List: Maternal mortality ratio (per

100 000 live births) https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26

2 Ibid.

3 Trost SL, Beauregard J, Njie F, et al. Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017-2019. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services; 2022. https://www.cdc.gov/reproductivehealth/maternal-mortality/erase-mm/data-mmrc.html

4 Lawn R B, Koenen K C. Homicide is a leading cause of death for pregnant women in US BMJ 2022; 379 :o2499 doi:10.1136/bmj.o2499

5 World Health Organization. Abortion care guideline. 2022, Geneva. https://www.who.int/publications/i/item/9789240039483

6 Zernike, Kate. "What Does 'Abortion' Mean? Even the Word Itself Is Up for Debate." New York Times, October 18, 2022. https://www.nytimes.com/2022/10/18/us/abortion-roe-debate.html

7 Dublin Declaration on Maternal Healthcare. 2012. https://www.dublindeclaration.com/

8 WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Trends in maternal mortality 2000 to 2020. 2023. https://www.who.int/publications/i/item/9789240068759

9 Centers for Disease Control and Prevention. "Achievements in Public Health, 1900-1999: Healthier Mothers and Babies." October 1, 1999. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4838a2.htm

10 WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Trends in maternal mortality 2000 to 2020, ibid.

11 Declercq, Eugene, and Zephyrin, Laurie. Maternal Mortality in the United States: A Primer. The Commonwealth Fund Data Brief, December 2020. https://www.commonwealthfund.org/sites/default/files/2020-12/Declercq_maternal_mortality_primer_db.pdf

12 Calhoun B. The Maternal Mortality Myth in the Context of Legalized Abortion. Linacre Q. 2013 Aug;80(3):264-276. doi: 10.1179/2050854913Y.0000000004.

13 Aid Access. FAQ: Is it safe to use abortion pills while alone? https://aidaccess.org/en/page/443/why-shouldn-t-you-be-alone-when-you-do-a-medical-abortion-and-what-if

14 Aid Access. FAQ: How do you know if you have abortion complications? https://aidaccess.org/en/page/459/how-do-you-know-if-you-have-complications-and-what-should-you-do

15 Lawn and Koenen, 2022, ibid.

16 Murez, Cara. "Homicide a Leading Cause of Death for Pregnant U.S. Women." U.S. News and World Report, October 20, 2022. https://www.usnews.com/news/health-news/articles/2022-10-20/homicide-a-leading-cause-of-death-for-pregnant-u-s-women

17 United Kingdom. National statistics: Abortion statistics, England and Wales: 2021. Updated Updated 25 May 2023. https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021

18 Surana, Kavitha. "Maternal Deaths Are Expected to Rise Under Abortion Bans, but the Increase May Be Hard to Measure." ProPublica, July 27. 2023. https://www.propublica.org/article/tracking-maternal-deaths-under-abortion-bans

19 Mac Donald, Sarah. "PLC: Savita's death was about mismanagement." Catholic Ireland, September 12, 2014. https://www.catholicireland.net/plc-review-shows-savitas-death-mismanagement/

20 Hogan, Margaret C. et al. Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. The Lancet, Volume 375, Issue 9726, 1609 – 1623 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)60518-1/

21 APHRC. "About Us." https://aphrc.org/who-we-are/

22 APHRC. "Funders and Partners." https://aphrc.org/funders-and-partners/

23 Incidence and Complications of Unsafe Abortion in Kenya: Key Findings of a National Study (Nairobi, Kenya: African Population and Health Research Center, Ministry of Health, Kenya, Ipas, and Guttmacher Institute 2013). https://www.guttmacher.org/sites/default/files/pdfs/pubs/abortion-in-Kenya.pdf

24 Correnti, Lisa. "Sweden Targets Africans Using "Unsafe Abortion" Study." The Friday Fax, April 16, 2020. Center for Family and Human Rights. https://c-fam.org/friday_fax/sweden-targets-africans-using-unsafe-abortion-study/

25 Correnti, Lisa, ibid.

26 Koch E. Impact of reproductive laws on maternal mortality: the Chilean natural experiment. Linacre Q. 2013 May;80(2):151-60. doi: 10.1179/0024363913Z.00000000022.

27 Ministry of Health, African Population and Health Research Center, Ipas. The costs of treating unsafe abortion complications in public health facilities in Kenya. 2018. https://aphrc.org/wp-content/uploads/2019/07/The-Costs-of-Treating-Unsafe-Abortion-Complications-in-Public-Health-Facilities-in-Kenya_Final.pdf

28 Gennarini, Stefano, and Oas, Rebecca. "UN-safe Abortion: How the Abortion Industry has Used UN Agencies to Legitimize Abortion." Definitions, August 1, 2020. Center for Family and Human Rights. https://c-fam.org/definitions/un-safe-abortion-how-the-abortion-industry-has-used-un-agencies-to-legitimize-abortion/

29 Ganatra, Bela, Tunçalp, Özge, Johnston, Heidi Bart, Johnson Jr, Brooke R, Gülmezoglu, Ahmet Metin. et al. (2014). From concept to measurement: operationalizing WHO's definition of unsafe abortion. Bulletin of the World Health Organization, 92 (3), 155. World Health Organization. http://dx.doi.org/10.2471/BLT.14.136333

30 Oas, Rebecca. The World Health Organization's Abortion

Overreach. International Organizations Research Group, White Paper Number 13. 2020, Center for Family and Human Rights. https://c-fam.org/white_paper/the-world-health-organizations-abortion-overreach/

31 Incidence and Complications of Unsafe Abortion in Kenya, 2013, ibid.

32 Geneva Consensus Declaration on Promoting Women's Health and Strengthening the Family, 2020, https://undocs.org/en/A/75/626.

33 Sadinsky, Sophia and Ahmed, Zara. "A Time for Change: Advancing Sexual and Reproductive Health and Rights in a New Global Era." 2021. Guttmacher Institute. https://www.guttmacher.org/sites/default/files/article_files/gpr2401421.pdf